

is observed in 31%, and 8% are with three medicines. Using the “decision tree” model the monthly cost of mono therapy is 9.71 BGL, for di therapy is 17.77 BGL and three therapy is 25.24 BGL (exchange rate 1.95 BGL = 1 EURO). The total yearly cost of outpatient therapy accounts for approximately 242 million BGL with 65% patients’ co-payment. Sensitivity analysis shows that the cost of the therapy is influenced more on changes in the price of medicines than on therapy complexity. **CONCLUSION:** The hypertension is an expensive disease with heavy burden of co-payment for the Bulgarian patients.

**PCV41****COSTS AND LENGTH OF STAY IN PATIENTS HOSPITALIZED FOR ACUTE HEART FAILURE**

Ondrackova B<sup>1</sup>, Miklik R<sup>2</sup>, Parenica J<sup>2</sup>, Spinar J<sup>2</sup>, Sticha M<sup>1</sup>

<sup>1</sup>Masaryk University, Brno, Czech Republic, <sup>2</sup>Faculty Hospital Brno, Brno, Czech Republic

**OBJECTIVES:** Using retrospective cost analysis was to estimate direct in-patient costs and length-of-stay (LOS) in hospital for acute heart failure (AHF) with one-year follow-up. **METHODS:** Patients were hospitalized with acute decompensation (ADHF) or new-onset of AHF in the Faculty Hospital Brno from January till December 2005. Burden incurred is divided to standard cardiology unit (SCU) and intensive care unit (ICU). In-patient care costs include flat rate of admission, stay and medicinal procedures. The pharmaceuticals are included in daily in-patient rate; angiography, revascularisations and antiarrhythmics are calculated separately. The subsequent hospitalizations were followed for one year. **RESULTS:** In total, 734 patients (57% male, mean age 71.7 years) with AHF were analysed. New-onset of AHF (58.6%) was more common than ADHF; according to the clinical classification AHF with mild signs and symptoms prevailed (46%). The overall direct hospital cost of all patients within first hospitalization was €2.4 million, LOS 8.3 days and mean in-patient cost was €3295 (including all interventions). Mean LOS in the SCU was 8.3 days with one-day cost of €55; mean LOS in the ICU was 3.4 days with one-day cost of €618. Cardiogenic shock was associated with highest hospitalization costs (€4156). Total cost of cardiac catheterisations and revascularisations (50% patients) was €952,247; cost of antiarrhythmic interventions (PM and ICD; 6.9% patients) was €529216. Mortality during first hospitalization was 14.6%. Most patients were hospitalized due to AHF within 1–3 months after first admission without relation between hospitalization rates. **CONCLUSION:** AHF hospitalization is a significant source of health care expenditures and has become more frequent as the population ages and medical care improves survival after acute coronary syndromes. AHF is associated with poor prognosis and high costs during hospital admission; the predominant contributors of high costs are revascularisation procedures (40%), stay in the ICU (31%) and antiarrhythmic interventions (22%).

**PCV42****ANTICOAGULATION CONTROL IN DIFFERENT SETTINGS OF CARE: PERCEPTION, DIRECT NON-HEALTH CARE COSTS AND PRODUCTIVITY LOSSES AMONGST PATIENTS WITH ATRIAL FIBRILLATION IN AN ITALIAN REGION**

Aguzzi G<sup>1</sup>, Fattore G<sup>1</sup>, Falcone A<sup>2</sup>, Agnelli G<sup>3</sup>

<sup>1</sup>Bocconi University, Milan, Italy, <sup>2</sup>AstraZeneca Italia, Basiglio, Italy,

<sup>3</sup>Perugia University, Perugia, Italy

**OBJECTIVES:** The purpose of the study was to evaluate the economic burden directly borne by the patient affected with Atrial Fibrillation, and the satisfaction associated with monitoring of Oral Anticoagulation Therapy (OAT) in different settings

of care, in an Italian Region (Umbria). **METHODS:** A prospective, observational and multi-centre (5 centres: 3 anticoagulation clinics—ACs—and 2 usual settings of care—USCs) study was designed. Data were collected through case report forms created ad hoc. Study perspective was the patient’s, thus the costs sustained by the Italian NHS were excluded, and only direct non-health care costs (out-of-pocket expenses covered either by the patient or by caregivers for non-health care related services) and patient’s and caregiver’s productivity losses were taken into account. Satisfaction with anticoagulation management was measured by the specific Duke Anticoagulation Satisfaction scale (DASS), together with the generic quality of life SF-36 form, both administered at day one and at the end of the observation period. **RESULTS:** A total of 101 patients in ACs and 51 in USCs were consecutively enrolled. The number of monitoring performed on a yearly basis resulted 3.5 tests less (–17%) for ACs compared to USCs (p-value 0.000), while the total time spent of each control was 7.1 hours less (–47%) for ACs (p-value 0.000). Direct non-health care costs and production losses per patients on a yearly basis amounted to an average of Euro 274.5 without significant differences amongst ACs and USCs. DASS in ACs resulted on average 0.5 points lower than USCs (p-value 0.001): patients in ACs felt less limitations on physical activities (–0.8 points, p-value 0.001), hassles (–1.0 points, p-value 0.000) and burdens (–0.6 points, p-value 0.001). The SF-36 did not detect any significant difference in the general health status. **CONCLUSION:** ACs appears to be the preferred setting of care for OAT monitoring when considering patient’s perspective.

**PCV43****DIRECT COSTS ASSOCIATED WITH THE POTENTIAL COMPLICATIONS OF INCREASED CARDIOMETABOLIC RISK STATES**

Nagy J<sup>1</sup>, Borsos K<sup>2</sup>, Belicza É<sup>3</sup>, Skultéty L<sup>1</sup>, Vándorfi G<sup>4</sup>, Nagy B<sup>1</sup>

<sup>1</sup>GKI-EKI Healthcare Research Institute Ltd, Budapest, Hungary,

<sup>2</sup>sanofi-aventis Zrt, Budapest, Hungary, <sup>3</sup>Semmelweis University, EMK,

Budapest, Hungary, <sup>4</sup>Csolnoky Ferenc Hospital, Veszprem County,

Veszprém, Hungary

**OBJECTIVES:** Global cardiometabolic risk represents the overall risk of developing type 2 diabetes (T2DM) and/or cardiovascular disease (including MI and stroke), which is due to a cluster of modifiable risk factors/markers. The objective of our study is to determine the direct medical costs imposed on the Insurer in Hungary relation with the treatment of the most important cardiovascular diseases and T2DM. **METHODS:** Individual-level treatment data of 16,880 patients suffering of Acute myocardial infarction (AMI), angina, stroke, and transient ischemic attack (TIA) and having primary care at a inpatient institute were processed by using financing database containing reimbursement data of 2-year outpatient and inpatient cares. The mean costs of cardiovascular disease were divided into sub-costs of acute treatment and of 6-month follow-up treatment. Cost of T2DM was calculated using a doctor’s questionnaire assessing the probability (frequency) of interventions, and treatments specified in the current guideline. 2005 price level were used. **RESULTS:** The mean acute treatment costs of AMI was €932 (fatal) and €2017 (non-fatal); of angina was €1489; of stroke was €935 (fatal) and €1056 (non-fatal); of TIA was €781 to the Insurer. The 6-month follow-up cost in case of T2DM was €350, AMI was €2006, angina was €1679, stroke was €3110 and TIA was €1749. **CONCLUSION:** According to our calculations, the main complications of cardiometabolic risk represent significant expenses to the Insurer. The results give opportunity to evaluate the cost-effectiveness of health technologies used in the management of cardiometabolic risks factors.